STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		155777	A. BUILDING		02/29/2012
		1	B. WING	ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>
NAME OF P	PROVIDER OR SUPPLIER	₹		CREASY LN	
CREASY	SPRINGS HEALTI	H CAMPUS		ETTE, IN 47905	
				_ , , , , , , , , , , , , , , , , , , ,	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	KEGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This is	water to the control of	F0000	The submission of this BOO !	000
		or the Investigation of	1.0000	The submission of this POC d not indicate an admission by	UCS
	Complaint IN00	103679.		Creasy Springs Health Campu	ıs
				that the findings and allegation	
	Complaint IN00	103679 - Substantiated.		contained herein are accurate	
	Federal/State det	ficiencies related to the		and true representations of the	е
	allegations are cited at F279, F309, F323.			quality of care and services	
				provided to the residents of	
	Survey Dates: F	February 28, 29, 2012		Creasy Springs. The facility maintains it is in substantial	
	2			compliance with the requirement	ents
	Facility Name	. 012285		of participation for comprehen	
	Facility Number			health care facilities. This PO	
	Provider Numbe			will serve as the credible	
	AIM Number: 20	01006770		allegation of compliance with a	all
				federal and state requirments	,
	Survey Team:			governing the management of	
	Linda Campbell,	, RN		this facility.	
	Census Bed Typ	e:			
		8			
	SNF: 49				
		47			
	Total: 104				
	10101. 104				
	Comment	.m.o.t			
	Census Payor Ty	ype:			
	Medicare: 27				
	Other: 77				
	Total: 104				
	Sample: 4				
	Sample. 4				
	These deficienci	es also reflect state			
		accordance with 410 IAC			
	16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

JVU711

Facility ID:

012285

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMF 02/29	E SURVEY PLETED 9/2012
	PROVIDER OR SUPPLIE Y SPRINGS HEALT		1750 S	ADDRESS, CITY, STATE, ZI CREASY LN ETTE, IN 47905	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
	Quality review williams, RN	3/01/12 by Suzanne				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JVU711

Facility ID: 012285

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155777	A. BUIL B. WINC			02/29/	2012
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CREASY LN		
CREASY	SPRINGS HEALTH	H CAMPUS			ETTE, IN 47905		
(X4) ID		TATEMENT OF DEFICIENCIES	,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGERET		DATE
F0279 SS=D		PREHENSIVE CARE					
	PLANS						
	•	se the results of the					
	assessment to develop, review and revise the resident's comprehensive plan of care.						
	resident's compr	enensive plan of care.					
	The facility must	develop a comprehensive					
		ch resident that includes					
	•	ctives and timetables to					
		s medical, nursing, and					
		hosocial needs that are					
		comprehensive assessment.					
	The care plan m	ust describe the services that					
	-	ed to attain or maintain the					
	_	st practicable physical,					
		chosocial well-being as					
		483.25; and any services					
		wise be required under not provided due to the					
		se of rights under §483.10,					
		nt to refuse treatment under					
	§483.10(b)(4).						
	Based on record	review and interview, the	F027	79	1) Resident D discharged on		03/19/2012
		ensure residents' care			12/26/11. For resident B, the		
		lete and updated for 2 of			facility developed a	10	
		wed for care plans in a			pacemaker care plan on 2/29/which addressed parameters,	12	
		sidents #B and #D).			frequency of heart rate checks		
	Sample of 4. (Re	ordento no una noj.			and physician orders for	•	
	Eindings in aluda				pacemaker check		
	Findings include	•			appointments.2) Current		
	1 Dogiđana #DI	aliminal managed re-s			residents in Health center had their fall care plans reviewed		
		clinical record was			addressing the the accuracy of	f	
		0/12 at 8:15 A.M. The			fall risks and assuring that all	1	
		the resident had a			interventions were in place and	d	
	-	ant. The record also			appropriate. On March 1, 2012		
	indicated the resi	ident had been readmitted			nursing management staff		
	from the hospital	to the facility on			identified 4 of 57 residents with		
	•	-			pacemakers through chart aud	IITS.	

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Event ID: JVU711

Facility ID: 012285

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED
		155777	B. WIN			02/29/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			CREASY LN	
CREASY	SPRINGS HEALTI	H CAMPUS			ETTE, IN 47905	
					1112, 114 47 300	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	2/20/12.				Physician orders were obtaine for parameters, frequency of	ď
					heart rate checks, and	
	Documentation v	was lacking in the clinical			pacemaker check appointmen	ts.
	record to indicate	e what type of pacemaker			All Residents identified	
	the resident had	implanted.			have updated pacemaker care	<b>;</b>
		•			plans inplace 3) Nursing	
	A physician orde	ers recapitulation dated			administation will review each	
		ndicated documentation			new admission and readmision	n
					for fall care plans to assure interventions are appropriate t	
	was lacking related to the frequency the				prevent falls. All residents with	
	resident's pulse should be taken or pulse				falls will be reviewed by	
		o indicate when the			nursing administration to assu	re
	physician should	be notified.			all careplans are updated with	
					appropriate and new intervent	
	Interview on 2/2	9/12 at 9:40 A.M. with			in place.The DHS or designee	will
	the Director of N	Jursing indicated the			review charts on all new admissions and readmissions	to
		hould be checked daily.			see if Residents have	10
	_	ere were no pulse			a pacemaker present, Physicia	an
		red by the physician.			orders for parameters, frequer	
	parameters order	ed by the physician.			of heart rate checks, and	
	A UNI main a A for	: A Q			pacemaker appointments. A	
	_	nission Assessment &			pacemaker care plan will be in	1
		form dated 2/20/12,			place upon admission and	:4
		ac Plan of Care." Further			nursing administration will aud all new admissions and	"
		"Pacemaker checks as			re-admissions daily. All license	ed
	ordered due Mar	'12" Documentation			nursing staff have been	
	was lacking relat	ted to checking the			inserviced on falls and safety	
		and related to pulse			management progam policy a	
		ne resident's pacemaker.			procedures.All licensed staff h	
	1	r			been inserviced on pacemake	
	Interview on 2/2	9/12 at 9:40 A.M. with			policy and procedures including obtaining physician orders for	9
		Jursing indicated the care			parameters, frequency of hear	t l
		•			rate checks, and pacemaker	
	^	Nursing Assessment			appointments and initiating a c	are
		ted there were no pulse			plan on admission. 4) DHS or	
	parameters on th	e care plan.			designee's daily audits will be	
					reviewed in Monthly QAA for 6	

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Event ID: JVU711

Facility ID: 012285

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155777	B. WIN			02/29/	2012
			D. 111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			CREASY LN		
CREASY	SPRINGS HEALTI	H CAMPUS			ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Review on 2/29/	12 at 10:30 A.M. of an			months to assure		
	undated facility	policy and procedure,			substantial compliance.		
	provided by the	Director of Nursing,					
	identified a current, and titled "Guidelines						
	for Pacemaker"	<i>'</i>					
		provide the facility with					
		imum heart rate above					
		ate that is acceptableThe					
	physician shall provide the programmed						
	lower and upper rate for the						
	pacemakerPulse shall be taken per the						
	-						
	physician orders	"					
	2. Resident D's	clinical record was					
	reviewed on 2/28	8/12 at 1:15 P.M. The					
	record indicated	the resident had fallen on					
		ultant fracture of the left					
	femur.						
	Temur.						
	A "Fall Circums	tance, Assessment and					
	Intervention" for	rm dated 11/5/11					
	indicated "Prev	vention Updatehad res					
	(resident) @ Nu	-					
	, , ,	assess upon return from					
	hospital"						
	Interview on 2/2	8/12 at 9:40 A.M. with					
		Nursing indicated the					
		r the fall was to "educate					
	uie resident to us	se the can fight."					
	A resident care p	olan dated 9/20/11					
	indicated "Falls.	at risk for fall/injury"					
	Documentation v	was lacking related to					
	indicated "Falls.	olan dated 9/20/11 at risk for fall/injury"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JVU711

Facility ID: 012285

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00 	COM	E SURVEY PLETED 0/2012
		155777	B. WING			9/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C	CODE	
CREASY	SPRINGS HEALTI	H CAMPUS		CREASY LN ETTE, IN 47905		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LEG INFORMATIONS	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		resident or having the arses' station to monitor.				
	This federal tag IN00103679.	relates to complaint				
	3.1-35(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JVU711

Facility ID: 012285

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155777	B. WIN	G		02/29/	2012
	PROVIDER OR SUPPLIER			1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
F0309 SS=G	483.25 PROVIDE CARE WELL BEING Each resident mi must provide the services to attain practicable physi psychosocial we the comprehensi care. Based on intervice facility failed to provided necessa related to obtaini the physician afte continued pain at 1 of 3 residents w obtaining paceme resident with a pa 4. (Residents #B  Findings include  1. Resident #D's was reviewed on The record indica admitted with dia but were not limit femur, osteoarthe walking. The res to the facility afte home resulting in  Nurses' notes ind fallen on 11/5/11	e/SERVICES FOR HIGHEST  ust receive and the facility necessary care and or maintain the highest ical, mental, and ill-being, in accordance with ve assessment and plan of  ew and record review, the ensure residents were ary care and services ing an x-ray as ordered by er a fall resulting in and delay in treatment for with falls and related to aker parameters for 1 of 1 accemaker, in a sample of and #D).	F03		1) Resident D discharged on 12/26/11. For resident B, the facility developed a pacemake care plan and obtained Physic orders on 2/29/12 which addressed parameters, freque of heart rate checks and appointments for pacemakers Current Residents that sustair a fall within the past 30 days a continue to complain of pain related to the fall have been reviewed. On March 1, 2012, nursing administration staff identified 4 of 57 residents wit pacemakers through chart aud Physician orders were obtaine for parameters, frequency of heart rate checks, and pacemaker check appointments. Pacemaker car plans were implemented.3) Current residents that have fa and continue to complain of pain will be assessed and physicia will be notified for further orde All licensed nursing staff have been inserviced on falls and safety management progam policy and procedures. All physician orders for X-rays and the monitoring of pain after a face of the pace of the page of	er cian ency .2) ned and h dits. ed	03/19/2012

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Event ID: JVU711

Facility ID: 012285

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AND PLAN OF CORR	RECTION						
	RECTION	IDENTIFICATION NUMBER:	л ріш	DINC	00	COMPLI	ETED
		155777	A. BUII B. WIN		<del></del>	02/29/2	2012
			B. WIN		DDDEGG CITY CTATE ZID CODE		
NAME OF PROVIDER	ER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
005407.0001	NOO 11541 TI	LOAMADUO			CREASY LN		
CREASY SPRIN	NGS HEALTF	1 CAMPUS		LAFAYE	ETTE, IN 47905		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EA	EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG REC	EGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
A "Sk Collectindicatoilet. gettin return front of back is over the device W/C of (no) normal W/C for 2-  A physindicatory indicatory of the policy of the	skilled Nursing ection" form cated "Rest. Informed stang drsg (dresten res calling to f toilet. Rest. In her W/C to get TED (ces) hose et f. via 2 staff. So) increase (in hal once up (ces) hose et f. via 2 staff. So) increase (in hal once up (ces) hose et f. via 2 staff. So) increase (in hal once up (ces) hose et f. via 2 staff. So) increase (in hal once up (ces) hose dated "11/20/D/T (due to) get (continues) of cated by arrow (hospital) for the leanegative for not xrayed.  Autrest of the leanegative for not xrayed.  Autrest of the leanegative for not xrayed.  Autrest of the leanegative for not xrayed.	ng Assessment and Data dated 11/20/11 (no time) (resident) placed on staff to be back was ssing) supplies. Upon out et (and) on floor in se states she put herself (wheelchair) et leaned (antithrombolytic fell out of W/C. Assist to Some pain to hips x 2 but indicated by arrow) than indicated by arrow) in dicated by arrow) in W/C s)"  Her dated 11/20/11 (11 May xray (L) (left) pain. If (-) (negative) et ce (with) increased ow) pain may send to		IAG	will be audited daily to ensure physician order is implemented timely. All licensed staff have be inserviced on pacemaker policiand procedures including obtaining physician orders for parameters, frequency of hear rate checks, and pacemaker appointments and initiating a coplan on admission. 4) DHS or designee's daily audits will be reviewed in Monthly QAA for 6 months to assure substantial compliance.	d een y t	DATE

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Event ID: JVU711

Facility ID: 012285

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777			ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  02/29/2012
	PROVIDER OR SUPPLIE		1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	has good ROM: previous hip fx ( 9 of 10 & whole redness noted or	d at all on that leg. Res for that leg - given (fracture). Res stating pain e leg tender to touch. No n left leg. Res had ice on eewill continue to			
	dated 11/13/11 tindicated "Normedication) 10/2 PO (by mouth) of PRN (as needed given 4 times or review indicated PO q 6 hrs"	dministration Record through 11/30/11 reo (a narcotic pain 325 mg (milligrams) 1/1 q (every) 3 hrs (hours) )" The Norco had been a 11/20/11. Further I "Norco 10/325 mg 1/1 The Norco had been given M, 11AM, 5PM, and			
	Collection" forn	ing Assessment and Data n indicated: A.M. "Distressed -			
	penA & O x 3 three) but very c (antianxiety med (administered) p Documentation	table c (with) cup et (and) (alert and orient times confusedXanax dication) adm er PRN order" was lacking related to an me resident's leg or pain.			
		A.M. "Res in bed. pp+ sitive) bil (bilateral) (l)			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLI	ETED
		155777	A. BUI B. WIN	LDING		02/29/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
CDEACY	CODINCO LIEALTI	LL CAMPLIC			CREASY LN		
CREAST	SPRINGS HEALT	H CAMPUS		LAFAYE	ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	upper (indicated	by arrow) leg c (with)					
	edema. N.O. order received to xray femur						
		ny name) calledXray					
	` .	fx (fracture) to (L)Res c					
		us) pain. Has diff					
	I ` • ′	ing L (left) footN.O.					
	(new order) to di	irect admit res to (hospital					
	name)"						
	An xray report d	lated 11/22/11 indicated					
	"There is a fracture involving left mid to						
	distal femur with modest						
	-	acute appearing left femur					
	fracture"						
	Interview on 2/2	9/12 at 9:40 A.M. with					
		Nursing indicated "I have					
		for why she wasn't sent to					
	_	-					
	_	additional xrays. She					
		ident should have been					
	sent on 11/20/11						
	Review on 2/29/	12 at 9:10 A.M. of a					
		nd procedure dated 1/06,					
		Director of Nursing,					
		•					
		rent, and titled "Falls					
	_	ogram Guidelines"					
	indicated "Any	y orders received from the					
	physician should	d be noted and carried					
	out"						
	2 Pagidant #Dla	s clinical record was					
		9/12 at 8:15 A.M. The					
	record indicated	the resident was admitted					

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Event ID: JVU711

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	
		155777	B. WING			02/29/	2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					CREASY LN		
CREASY	SPRINGS HEALTH	H CAMPUS		AFAYE	ETTE, IN 47905		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1.	AG	DEFICIENCY)		DATE
	with diagnoses which included, but were						
	not limited to, acute respiratory failure,						
		ve pulmonary disease,					
	lung cancer, and	pacemaker.					
	A ab agt	out dated 1/0/12 : 1: 4: 1					
		ort dated 1/9/12 indicated					
	I nere is a pac	emaker in position"					
	Documentation v	was lacking in the clinical					
	Documentation was lacking in the clinical record to indicate what type of pacemaker						
	the resident had	J 1					
	the resident had	impianica.					
	A "Nursing Adm	nission Assessment &					
		form dated 2/20/12,					
		ac Plan of Care." Further					
		"Pacemaker checks as					
		'12" Documentation					
		ted to checking the					
		and related to pulse					
	_	ne resident's pacemaker.					
	parameters for th	ie resident's pacemaker.					
	A nhysician orde	ers recapitulation dated					
		ndicated documentation					
		ted to the frequency the					
		hould be taken or pulse					
	_	o indicate when the					
	-						
	physician should	DE HUIHIEU.					
	Interview on 2/2	9/12 at 9:40 A.M. with					
		Jursing indicated the					
		hould be checked daily.					
	_	_					
		ere were no pulse					
	parameters order	red by the physician.					

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Facility ID: 012285

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155777		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (OOPLETED O2/29/2012)			
		133777	B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	02/29/2012
	PROVIDER OR SUPPLIE		1750 S	CREASY LN	
CREASY	SPRINGS HEALT	H CAMPUS	LAFAY	ETTE, IN 47905	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	REGULATORY OF Review on 2/29 undated facility provided by the identified a curre for Pacemaker" physician shall p the specific max the pacemaker re physician shall p lower and upper pacemakerPul physician orders	R LSC IDENTIFYING INFORMATION)  /12 at 10:30 A.M. of an policy and procedure, Director of Nursing, ent, and titled "Guidelines indicated "The provide the facility with himum heart rate above attended that is acceptableThe provide the programmed that rate for the se shall be taken per the		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777  NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDERS PLAN OF CORRECTION  OO COMPLETED 02/29/2012  STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905	
NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905	(X5) MPLETION
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN  LAFAYETTE, IN 47905  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  ID	MPLETION
NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  ID  1750 S CREASY LN  LAFAYETTE, IN 47905	MPLETION
CREASY SPRINGS HEALTH CAMPUS LAFAYETTE, IN 47905  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	MPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	MPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDEDS BLANGE CORPORTION	MPLETION
CROSS-REFERENCED TO THE APPROPRIATE	DATE
' land	
F0323 483.25(h) SS=G FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	3/19/2012

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155777	B. WIN			02/29/2	2012
NAME OF D	DROWINED OR STIDDLIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF			1750 S	CREASY LN		
	SPRINGS HEALTI	H CAMPUS		<u> </u>	ETTE, IN 47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	ì ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	1.16°	C + A FDC) A 1 · · ·					
		a Set (MDS) Admission					
		1 9/27/11, indicated the					
	l	nitively intact, required					
	_	erson physical assistance					
		non-ambulatory, required					
	·	erson assistance for toilet					
		not assessed, and had a					
	fracture related t	o a fall in the previous 6					
	months.						
	A "Nursing Adm	nission Assessment &					
	Data Collection"	form dated 9/20/11,					
	indicated "Has	cognitive impairment					
	that effects safet	y/judgement @ (at) times					
	Y (yes)Has a h						
		ds (medications) that may					
		ognition or gait Y					
	· ·	pliant with safety					
	`* ′	es Y (yes)" Further					
	_	"Safety Plan of					
		ssistance for transfers and					
		ededToilet resident per					
		eEnsure call light is					
	_	oserve for compliance					
		ventionsInstruct					
	I						
	resident on use of	ı can iigiit					
	A regident some =	Jan datad 0/20/11					
		olan dated 9/20/11,					
		isk for fall/injury AEB					
	(as evidenced by						
	FallsPotential						
		onsCall light within					
	reachLock brea	aks (sic) on bed, chair etc					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL		
		155777	A. BUIL B. WING			02/29/	2012
	PROVIDER OR SUPPLIEI			1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	lying position, si	ngWhen rising from a it on side of bed for a few ransferring/stand"					
	Nurses' notes inc	licated:					
	found on floor in toilet & sitting of pain in extremiting (right) side of he	P.M. "Res (resident) a bathroom next to her in her butt. Denied any es but had bumped the Rt er forehead. Ice applied to formedRes able to move s (without) diff					
	inspection - disc hematoma had for filled but 0 (no) also has 2 1 cm of Rt elbow. Ice ap - res denies pain (range of motion 11/6/11 at 1:00 A hip is starting to	A.M. "Upon further skin overed (sic) that a ormed on Rt hip - fluid redness or bruising. Res (centimeter) skin tears on plied to Rt hip hematoma & has normal ROM a) of that leg & hip"  A.M. "Res states her Rt hurt" At 1:45 A.M. the to the hospital by					
	11/6/11 at 5:45 A ER (emergency	A.M. "(Hospital name) room) nurse called to let was admitted for Rt hip					

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	OF CORRECTION  OF CORRECTION  155777	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 02/29/2012
	PROVIDER OR SUPPLIER  SPRINGS HEALTH CAMPUS	1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A "Fall Circumstance, Assessment and Intervention" form dated 11/5/11, indicated "Location of fallRes bathroomFound on floortransferring selftoiletingResident has cognitive or memory impairment that effects safety and judgement? Y (yes)Resident requires assistance to transfer? Y (yes)Resident requires assistance to ambulate safely with or without assistive device? Y (yes)Prevention updatehad res @ nurses station to monitorwill reassess upon return from hospital"  A hospital history and physical dated 11/6/11, indicated "X-ray of the pelvis shows right subcapital femoral neck fractureright hip fracture"  A "Nursing Admission Assessment & Data Collection" form dated 11/11/11, indicated "Has cognitive impairment that effects safety/judgement @ (at) times N (no)Has a history of falls Y (yes)Takes meds (medications) that may affect balance, cognition or gait N (no)Non-compliant with safety measures @ times N (no)" Further review indicated "Safety Plan of CareRefer to therapyEnsure call light is within reachObtain physician order for enabler (circled)Provide side rails for bed mobility. Full 2 (circled)"			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMI	E SURVEY PLETED 9/2012
	PROVIDER OR SUPPLIER		1750 S	ADDRESS, CITY, STATE, ZIP CREASY LN	CODE	
CREASY	SPRINGS HEALTH	H CAMPUS	LAFAY	ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG	A resident care prindicated documerelated to any adimplemented to particle 11/5/11 fall.  A "Physical Theorem (maximum) assist standing and is a injury"  Interview on 2/2' the Director of Noresident "used he indicated the resident delay and indicated the interview on the indicated the interview of the indicated "Resinformed staff to (dressing) supplication of the indicated the interview of the indicated "Resinformed staff to (dressing) supplication of the indicated the interview of the indicated "Resinformed staff to (dressing) supplication of the indicated the interview of the indicated "Resinformed staff to (dressing) supplication of the indicated the interview of the indicated "Resinformed staff to (dressing) supplication of the indicated the interview of the indicated the indicated the indicated the indicated the interview of the indicated t	entation was lacking ditional interventions brevent falls after the rapy Discharge 11/7/11 indicated tly requires max at with transfers and trisk for falls and 19/11 at 9:40 A.M. with fursing indicated the er call light." She ident was asked why she "Physical therapy told start moving." She ervention after the fall ucation."	TAG	DEFICIENCY)		DATE
		ed by arrow) than normal				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	
		155777	B. WING			02/29/	2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
CDEACY	CODINCE LIEALTI	I CAMPILIS			CREASY LN ETTE, IN 47905		
	SPRINGS HEALTI				11 1E, IN 47905		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710		ed by arrow) in W/CSat	12	710			DATE
	1 \	arrow) in W/C for 2-3					
	1 \	t 11:30 A.M. "(Company					
	` ′	ay done. Results are in et					
	(and) (-) (negative	_					
	(and) (-) (negative	(C)					
	A nhysician's ord	der dated 11/20/11,					
		kray (L) (left) hip D/T					
	1	(-) (negative) et cont c					
	, , <u>, , , , , , , , , , , , , , , , , </u>	(indicated by arrow) pain					
	, ,						
	may send to hosp (hospital) for xray"						
	Nurses' notes indicated:						
	Transes notes me	iioutou.					
	11/20/11 at 8:00	P M "Res cont					
		o (complain of) pain left					
	` ′	e general edema of that					
	1 ~ ~	on through the foot but					
	only pitting on the						
		ood ROM for that left -					
		ip fx (fracture). Res					
		10 & whole leg tender to					
	touchRes has i	2					
		Documentation was					
	1 2	the resident being sent					
	_	r additional x-rays.					
	11/22/11 at 9:00	A.M. "Res in bed. pp+					
		sitive) bil (bilateral) (L)					
		by arrow) leg c (with)					
	'	w order) received to xray					
	femur & knee. (C	,					
	,	ults in femur fx to					
	_	cont (continuous) pain.					
	(2)("1111)	tont (continuous) puni.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155777		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL 02/29/	ETED	
NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS			B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CREASY LN ETTE, IN 47905	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ty) moving (L) foot"		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	The resident was  A "Fall Circumst Intervention" for indicated "LocatallBathroomfloortransferring objectResident impairment that indigenent? N (not assistance to transfer assistance with or without assistance to transfer assistance to transfer assistance to transfer assistance with or without assistance to transfer assistance t	admitted to the hospital.  ance, Assessment and m dated 11/20/11 ation of Found on g selfreaching for has cognitive or memory effects safety and o)Resident requires sfer? Y (yes)Resident ce to ambulate safely assistive device? Y in updateNote in b/r ic) reminderPPA of to W/C et bed"  dated 11/22/11 indicated atture involving left mid to a modest cute appearing left femur  dission Assessment & form dated 11/30/11 cognitive impairment g/judgement @ (at) times istory of falls Y ds (medications) that may begintion or gait Y obliant with safety					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				onstruction 00	(X3) DATE COMPL		
		155777	A. BUII B. WIN			02/29/	2012
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CREASY LN		
	SPRINGS HEALTH			<u> </u>	ETTE, IN 47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	A resident care p	olan dated 11/30/11					
	indicated "At r	isk for					
	fall/injuryAddi	tional approaches: Bed					
	pad alarm, chair	pad alarm"					
	The resident exp	ired on 12/26/11.					
	Interview on 2/2	8/11 at 9:00 A.M. with					
		ector indicated the					
		expired due to the falls.					
		ave up and quit eating."					
		9/12 at 9:40 A.M. with					
		Jursing indicated the					
		en at 7:00 A.M. She					
		ould not have been left					
	alone in the bath	room.					
	Review on 2/29/	12 at 9:10 A.M. of a					
	facility policy an	d procedure dated 1/06,					
	provided by the	Director of Nursing,					
	identified as curr	ent, and titled					
	"Fall/Safety Mar	nagement Program					
	Guidelines" indi	cated "Care plan					
		ould be implemented that					
	address the resid	ent's risk factorsShould					
	_	erience a fall the attending					
	nurse shall comp						
		d Reassessment Form.'					
		esinterventions to					
		peat episode and a review					
	l • `	disciplinary team) to					
		hness of the investigation					
	and appropriaten	ess of the					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155777	A. BUILDING  B. WING	00	COMPLETED 02/29/2012			
NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  1750 S CREASY LN  LAFAYETTE, IN 47905					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	regulatory or interventionsAn the physician sho out"			(EACH CORRECTIVE ACTION SHOULD BE	IE			

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Event ID: JVU711

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